GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 27, 2021

Stephanie Hildebrant
Cliffside Company
910 S. Washington Av
Royal Oak, MI 48067

RE: License #: AL110270687
Investigation #: 2021A0579021
Caretel Inns of Royalton Eaton

Dear Stephanie Hildebrant:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

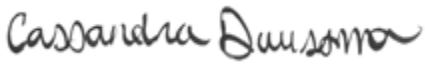
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,



Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa Ave NW, 7th Floor-Unit 13
Grand Rapids, MI 49503
(269) 615-5050

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AL110270687
Investigation #:	2021A0579021
Complaint Receipt Date:	03/12/2021
Investigation Initiation Date:	03/12/2021
Report Due Date:	05/11/2021
Licensee Name:	Cliffside Company
Licensee Address:	910 S. Washington Av Royal Oak, MI 48067
Licensee Telephone #:	(248) 330-9598
Administrator:	Stephanie Hildebrant
Licensee Designee:	Stephanie Hildebrant
Name of Facility:	Caretel Inns of Royalton Eaton
Facility Address:	3905 Lorrain Path St. Joseph, MI 49085
Facility Telephone #:	(269) 428-1111
Original Issuance Date:	10/04/2006
License Status:	REGULAR
Effective Date:	08/20/2019
Expiration Date:	08/19/2021
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility is inadequately staffed.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/12/2021	Special Investigation Intake 2021A0579021
03/12/2021	Special Investigation Initiated - Letter Stephanie Hildebrant, Licensee Designee
03/12/2021	Contact- Document Received Email received from Stephanie Hildebrant, Licensee Designee, with staff contact information.
03/16/2021	Contact- Document Sent Email sent to Stephanie Hildebrant, Licensee Designee, discussing coordinating for an on-site investigation.
03/20/2021	Contact- Document Received Text message from Direct Care Worker J
03/22/2021	Contact- Document Received Email response received from Stephanie Hildebrant, Licensee Designee, agreeing to coordinate for an on-site investigation.
03/22/2021	Contact- Document Sent Email sent to Stephanie Hildebrant, Licensee Designee, discussing coordinating for an on-site investigation.
03/23/2021	Contact- Document Sent Email sent to Stephanie Hildebrant, Licensee Designee, discussing coordinating for an on-site investigation.
03/31/2021	Contact- Document Received Email received from Stephanie Hildebrant, Licensee Designee, discussing coordinating for an on-site investigation.
04/08/2021	Contact- Document Sent Email sent to Stephanie Hildebrant, Licensee Designee, discussing coordinating for an on-site investigation.
04/09/2021	Contact- Telephone call made

	Direct Care Worker A
04/09/2021	Contact- Telephone call made Direct Care Worker B
04/09/2021	Contact- Telephone call made Direct Care Worker E
04/09/2021	Contact- Telephone call made Direct Care Worker F
04/09/2021	Contact- Telephone call made Direct Care Worker G
04/09/2021	Contact- Telephone call made Direct Care Worker C
04/09/2021	Contact- Telephone call made Direct Care Worker H
04/09/2021	Contact- Telephone call made Direct Care Worker I
04/09/2021	Contact- Telephone call made Direct Care Worker D
04/09/2021	Contact- Document Received Email response received from Stephanie Hildebrant, Licensee Designee, agreeing to be present for the on-site investigation 04/12/2021.
04/12/2021	Contact- Face to Face Stephanie Hildebrant (Licensee Designee), Candice Bearden (Direct Care Worker), Megan Aukerman (Licensing Consultant), Direct Care Worker T, Direct Care Worker U, and Residents A, B, and C.
04/14/2021	Contact- Document Sent Email sent to Stephanie Hildebrant, Licensee Designee, inquiring about staff clock-ins.
04/15/2021	Contact- Document Received Email response from Ms. Hildebrant reporting it would take additional time to receive staff clock-ins.
04/30/2021	Contact- Document Sent

	Email sent to Stephanie Hildebrant, Licensee Designee, inquiring about staff clock-ins.
05/03/2021	Contact- Document Received Email received from Stephanie Hildebrant, Licensee Designee, summarizing her review of staff clock-ins.
05/06/2021	Contact- Telephone call made Direct Care Worker O
05/06/2021	Contact- Telephone call made Direct Care Worker P
05/26/2021	Exit Conference Stephanie Hildebrant, Licensee Designee

ALLEGATION: The facility is inadequately staffed.

INVESTIGATION: On 03/12/2021, I entered this referral into the Bureau of Community Health System Bureau Information Tracking System after completing an on-site investigation at a connected facility where staff addressed concerns regarding insufficient staffing.

On 03/12/2021, I exchanged emails with Ms. Hildebrant and obtained the contact information for all Direct Care Workers (DCWs).

On 04/09/2021, I completed a telephone interview with DCW A. DCW A reported she has worked for CareTel for numerous years. She stated she has worked various shifts at the facility but primarily works third shift. She stated she has worked alone at this facility during first, second and third shift. She stated when she works alone, especially when residents are awake, she cannot provide adequate care to all the residents in the facility due to their care needs being more than one person can reasonably accommodate.

On 04/09/2021, I completed a telephone interview with DCW B. DCW B reported at times, when the facility is short-staffed during the day, and typically on third shift, there is only one DCW at the facility to care for residents.

On 04/12/2021, I completed an on-site investigation with the assistance of Licensing Consultant, Ms. Aukerman. Interviews were completed with Ms. Hildebrant, DCW T, DCW U, and Residents A, B and C.

Resident A was interviewed privately. Resident A stated she enjoys residing at the facility and the staff are “wonderful people”. She stated her needs are met and staff respond promptly when she calls for them.

Resident B and C were interviewed together, as they were having lunch. Both residents stated they enjoy residing at the facility and staff take good care of them. Both residents stated staff respond promptly when they need assistance.

DCW T was interviewed privately and stated she has not worked at the facility long; however, she feels the facility is adequately staffed and the residents are appropriately cared for. DCW T denied having any concerns.

DCW U was interviewed privately and stated she typically only works first shift. She stated she feels the facility has adequate staff to meet all the resident care needs. She stated if someone calls in, others will fill in to help.

While on-site I reviewed the written assessment plan for Resident A, B, C, D, E, F, H, I, J, L, M, N, O, P and Q. Resident C, K and Q did not have written assessment plans completed. Resident B, E, H, L, N, O and P were listed as transferring and ambulating independently. Resident A, G, I, J and M were listed as requiring "limited" assistance from one DCW with transferring and/or ambulating. Resident D and F were listed as requiring "extensive" assistance from two DCWs with transferring and/or ambulating.

I also reviewed written schedules from 03/24/2021, 03/31/2021, and 04/09/2021. The schedules noted there were two DCWs on 03/24/2021, 03/31/2021, and 04/09/2021 from 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM. There was one DCW on 03/24/2021, 03/31/2021, and 04/09/2021 from 11:00 PM to 7:00 AM. The schedule also listed a section for a "Float" staff, the position was not filled on 03/24/2021, 03/31/2021, and 04/09/2021.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	The written assessment plan for Resident D and F noted they require assistance from two Direct Care Workers with transferring and/or ambulating. The schedule for 03/24/2021, 03/31/2021, and 04/09/2021 noted there was only one Direct Care Worker from 11:00 PM to 7:00 AM each day. Direct Care Worker A reported she has worked alone at the facility during first, second and third shift. Direct Care Worker B reported there is usually one Direct Care

	Worker during third shift or during the day when the facility is short staffed. Due to the findings summarized above there is a preponderance of evidence to indicate the facility is not sufficiently staffed at all times to provide supervision, personal care, and protection of residents and to provide the services specified in the residents' assessment plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

On 04/09/2021, DCW A stated she has worked alone at the facility during first, second and third shift. She stated when she works alone, especially when residents are awake, she cannot provide adequate care to all the residents in the facility due to their care needs being more than one person can reasonably accommodate. She stated she has witnessed residents left in urine and/or feces soiled briefs when she arrives for her shift and staff from the previous shift report they could not toilet residents on their own.

On 04/09/2021, DCW B reported some DCWs use "being short-staffed as an excuse" to not toilet or transfer residents. She stated she has witnessed residents left in urine and/or feces soiled briefs for an excessive amount of time because staff claimed they could not toilet or transfer residents.

On 04/12/2021, DCW T stated she feels the facility is adequately staffed on first shift and the residents are appropriately cared for. She denied having any concerns.

On 04/12/2021, DCW U stated she typically only works first shift. She stated she feels the facility has adequate staff to meet all the resident care needs during first shift.

On 04/12/2021, Resident A stated her needs are met and staff respond promptly when she calls for them.

On 04/12/2021, Resident B and C stated they enjoy residing at the facility and staff take good care of them. Both residents stated staff respond promptly when they need assistance.

While on-site I reviewed the written assessment plans for Resident A, B, C, D, E, F, H, I, J, L, M, N, O, P and Q. Resident C, K, and Q did not have written assessment plans completed. Resident B, E, H, L, N, O and P were listed as transferring and ambulating independently. Resident A, G, I, J, and M were listed as requiring "limited" assistance from one DCW with transferring and/or ambulating. Resident D

and F were listed as requiring “extensive” assistance from two DCWs with transferring and/or ambulating.

I also reviewed written schedules from 03/24/2021, 03/31/2021, and 04/09/2021. The schedules noted there were two DCWs on 03/24/2021, 03/31/2021, and 04/09/2021 from 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM. There was one DCW on 03/24/2021, 03/31/2021, and 04/09/2021 from 11:00 PM to 7:00 AM. The schedule also listed a section for a “Float” staff, the position was not filled on 03/24/2021, 03/31/2021, and 04/09/2021.

On 05/06/2021, I received a text message from DCW P who stated she has observed residents left in urine and/or feces soiled briefs at Eaton House because staff did not toilet or transfer residents properly during their shift.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	The written assessment plans for Resident D and F documented that they require assistance from two Direct Care Workers with transferring and/or ambulating. The schedule for 03/24/2021, 03/31/2021, and 04/09/2021 documented there was one Direct Care Worker from 11:00 PM to 7:00 AM each day. Direct Care Worker A reported she has worked alone at the facility during first, second and third shift. Direct Care Worker B stated when the facility is “short-staffed”, she has witnessed residents left in urine and/or feces soiled briefs because staff reported they could not toilet or transfer residents appropriately. Direct Care Worker P stated she has observed residents left in urine and/or feces soiled briefs because staff did not toilet or transfer residents properly. Based on the interviews completed and documentation observed, there is a preponderance of evidence that residents did not receive sufficient supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

On 03/20/2021, DCW J sent me a text message stating DCW Z is *'trying to fill [staff] sign in sheets with people they know are not going to show up and are not even in town just so [Licensing] think[s] that [the home] is fully staffed.'* DCW Z is a Direct Care Worker with the title of Facility Director, who oversees all the facilities at this address.

On 04/09/2021, DCW A stated employee schedules are intentionally falsified by DCW Z to make it appear as if there are sufficient staff on duty even though the facility is "severely short-staffed." She stated she knows the schedules are intentionally falsified because on multiple occasions staff names have been placed on the schedule even though it is a shift they do not work. She stated staff are not notified they were placed on the schedule and therefore they do not show up to work. She stated there were multiple occasions where she had to call someone whose name was on the schedule, only to find out they would not be coming in because they did not know they were on the schedule and no one had contacted them. She stated staff who are known to have ended their employment will continue to be written on the schedule as well. She stated it is well known the employee has quit but their name will continue to be written down as if they were working. She stated any written or printed schedule would not be accurate. She stated the only accurate way to confirm who worked, would be to review staff clock-ins because anything managed by DCW Z would be falsified.

On 04/09/2021, DCW B stated staff schedules are intentionally falsified by DCW Z. She gave the example of DCW Q, whose name has been written on the schedule during weekdays to make it appear the schedule is full. She stated DCW Q only works two weekends a month and is not notified when she is placed on the schedule outside of those two weekends, so she does not arrive to work although her name is written on the schedule. She stated people who are no longer employed by the facility are written on the schedule as well.

On 04/09/2021, DCW H reported staff schedules are intentionally falsified. She stated names of employees are just written down, even if they are not notified that they were placed on the schedule or if they had ended their employment. She stated she knows this because it happened to her on one occasion. She stated she is "contingent" which means she only works two weekends a month. She stated one weekday, she was contacted by someone inquiring why she was not present for her shift. She stated her name was on the schedule, but she was not informed by anyone that she was assigned to work. She stated she has another job and was working that job. She stated she believes she was written in as a "no call, no show" but it is unfair because she was not notified that she was scheduled, nor is that a schedule she typically works.

On 04/09/2021, DCW C stated she has witnessed staff schedules being intentionally falsified by DCW Z. She stated that employee names are frequently just written down

without notifying the employee or with knowledge that the employee no longer works at the facility. She stated although there is a name on the schedule, the person does not show up. She stated this happens “all the time.”

On 04/09/2021, DCW I reported staff schedules are intentionally falsified. She stated “names are just put down” to make it appear there is sufficient staffing. She stated names of people who do not typically work that shift and are not notified that they were scheduled, are written in. She stated names of people who are known to have quit also continue to be written in to make the facility appear fully staffed.

On 04/09/2021, DCW F staff schedules are intentionally falsified by DCW Z. She stated names are written down for shifts or days employees typically do not work. She stated the written and printed staff schedules do not accurately reflect who is present for the shift.

On 04/09/2021, DCW G stated the staff schedule is not accurate. She stated often, names are written down and employees are unaware they are expected to be working because they were not notified. She stated this is done intentionally to make the schedule appear sufficiently staffed.

On 04/12/2021, I reviewed written schedules from 03/24/2021, 03/31/2021, and 04/09/2021. The schedules appeared to note schedule changes, the hours worked, the names of staff on duty, the job titles of staff on duty, and the date and hours worked.

On 04/12/2021, Ms. Hildebrant stated she was not aware of the allegation that staff schedules were being falsified. I reported that I had sufficient evidence to support that staff schedules were intentionally being falsified. She stated that she would review the record of employee clock-ins and provide that information to me.

On 04/14/2021, I inquired of Ms. Hildebrant via email if the record of employee clock-ins was available for my review. Ms. Hildebrant responded that it would take additional time for her to receive and review the employee clock-in record.

On 04/30/2021, I inquired again via email to Ms. Hildebrant if employee clock-in records were available for my review.

On 05/03/2021, Ms. Hildebrant responded to my email from 04/30/2021, that she had gone through timecards and realized there were primarily concerns with adequate staffing on the midnight shift. She stated they have started having management supervision on the midnight shift. She stated the evening supervision has been replaced and staff with problematic behavior were released from duty. Ms. Hildebrant did not include any mention of providing the employee “clock-in” record to me in her 05/03/2021 email.

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(c) Hours or shifts worked.** **(e) Any scheduling changes.**
ANALYSIS:	I reviewed written schedules from 03/24/2021, 03/31/2021, and 04/09/2021. The schedules documented schedule changes, the hours worked, the names of staff on duty, the job titles of staff on duty, and the date and hours worked. Direct Care Workers A, B, H, C, I, F and G reported staff schedules are falsified to make the facility appear sufficiently staffed. Each reported that the names of individuals who do not typically work certain shifts, certain days, or have knowingly ended their employment continue to be written down on the schedule without informing the individual they are scheduled. I asked Ms. Hildebrant multiple times to provide employee clock-in forms. Ms. Hildebrant did not provide those forms to me and instead summarized her findings from her own review of the clock-in forms noting there were primarily concerns with the staffing on third shift. Based on the interviews of staff who reported schedules are falsified, there is sufficient evidence to indicate that staff schedules do not accurately include the names of all staff on duty, hours and shifts worked, and any scheduling changes.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

On 03/20/2021, I received a text message from DCW J that stated, *'[DCW Z] is telling us [Licensing] are not our friend and we need to tell you guys that we never work alone.'* She also stated, *'DCW Z is trying to fill [staff] sign in sheets with people they know are not going to show up and are not even in town just so [Licensing] think[s] that [the home] is fully staffed.'*

On 04/08/2021, I exchanged emails with Ms. Hildebrant coordinating an on-site investigation. I requested DCW Z not participate in the scheduled on-site

investigation as I had concerns regarding her being intentionally deceitful and obstructive with the investigative process after completing an on-site investigation for a facility DCW Z also oversees on 03/09/2021.

On 04/09/2021, DCW B denied that DCW Z recently told her to give false information to licensing. She stated, however, that the staff schedules are intentionally falsified by DCW Z.

On 04/09/2021, DCW A stated DCW Z “lies about everything” and “falsifies paperwork to cover up concerns” within the facility. She stated the staff schedule is falsified because names of employees who do not work a certain shift, a certain day, or have knowingly ended their employment will continue to be placed on the schedule without notifying the scheduled individual. She stated the written schedule does not accurately note who worked, rather it makes it appear the facility is sufficiently staffed when it is not.

On 04/09/2021, DCW H reported staff schedules are intentionally falsified and she witnessed it firsthand when her name was put down for a day she does not work. She stated she found this out when staff called and asked why she was not at work. She stated the staff schedules are approved by DCW Z.

On 04/09/2021, DCW C stated she has witnessed staff schedules being intentionally falsified by DCW Z. She stated that employee names “are frequently just written down” without notifying the employee or with knowledge that the employee no longer works at the facility.

On 04/09/2021, DCW I reported staff schedules are intentionally falsified. She stated “names are just put down” to make it appear there is sufficient staffing and DCW Z is aware.

On 04/09/2021, DCW F stated staff schedules are intentionally falsified by DCW Z. She stated names are intentionally written down for people on shifts or days employees typically do not work without notifying the employee to make it appear the facility is adequately staffed. She stated when she and other staff members bring concerns to DCW Z, DCW Z does not address them, rather DCW Z “covers everything up.”

On 04/09/2021, DCW G stated often, names are written down and employees are unaware they are expected to be working because they were not notified. She stated this is done intentionally to make the schedule appear sufficiently staffed and DCW Z is aware.

On 04/20/2021, DCW B inquired why I had completed my investigation without any changes being made within the facility and implored me to investigate further. I inquired what she meant and reported that my investigation was not completed. She stated DCW Z held a “threatening meeting” on 04/19/2021, stating she “was aware of

what staff had said" and that "all concerns have been addressed" and "licensing said everything was fine." DCW B was advised that was not accurate and that my investigation was ongoing.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.
ANALYSIS:	Direct Care Worker J reported DCW Z advised staff not to cooperate with licensing. Direct Care Worker B reported DCW Z held a "threatening meeting" on 04/19/2021 where she told staff she was "was aware of what staff had said" and that "licensing said everything was fine." Direct Care Worker A noted DCW Z "lies about everything." Direct Care Worker B stated DCW Z "lies all of the time." Direct Care Worker F stated DCW Z "covers everything up." Direct Care Workers J, A, B, F, H, C, G, and I reported staff schedules are intentionally falsified with DCW Z's knowledge. Based on the interviews completed, there is sufficient evidence to indicate that not all employees who are under the direction of the licensee, primarily DCW Z, are suitable to assure the welfare of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

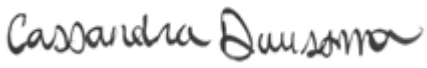
On 04/12/2021, I observed the assessment plan for each resident at Eaton. Resident C moved into the facility on 01/16/2021 and did not have a written assessment plan completed. Resident K moved into the facility on 04/01/2021 and did not have a written assessment plan completed. Resident Q moved into the facility on 03/09/2021 and did not have a written assessment plan completed.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.** **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.** **(c) The resident appears to be compatible with other residents and members of the household.** **(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.**
ANALYSIS:	Resident C, K and Q were observed to not have written assessment plans on file. Based on my review of documentation, Resident C, K and Q were accepted for care without written determination that they were suitable for the personal care, supervision, and personal care available, nor that the services, skills, and physical accommodations required were available, nor that residents are compatible with other residents. Additionally, a written assessment plan was not completed at the time of the resident admission.
CONCLUSION:	**VIOLATION ESTABLISHED**

05/26/2021, I completed an exit conference with Licensee Designee, Stephanie Hildebrant, who reported she disputes my findings pending further review of the written report.

IV. RECOMMENDATION

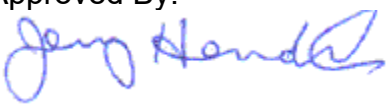
Contingent upon receipt of an acceptable plan of corrective action, I recommend a provisional license for the above-summarized quality of care violations.



05/26/2021

Cassandra Duursma — Date
Licensing Consultant

Approved By:



05/27/2021

Jerry Hendrick — Date
Area Manager